Basic Health™

You must return this form

Recertification Form

<MMMM/dd/yyyy>

I.D. #: *SSN*

<NAME>
<ADDRESS>
<CITY, STATE ZIP>

<GROUP I.D. & LANGUAGE CODE>

To continue your health care coverage, you must complete, sign, and date this form. Basic Health must receive all required documentation by <mm/dd/yy>.

Basic Health (BH) **must receive** the information checked below, along with this signed form (see the back of this page), by the due date above.

☐ **Copies of your and your spouse's federal income tax returns for the most recent tax year.** Include your IRS Form 1040 and all schedules filed, and forms K-1 if applicable – not your e-file transmittal sheet. If you don't have a copy, call the IRS at 1-800-829-1040 and request a transcript of your 1040. If you didn't file a 1040, send proof of nonfiling status from the IRS. If you are self-employed and have a Washington State Unified Business Identifier (UBI), write the number on the 1040.

☐ **Copies of pay stubs and proof of all income** for the last 30 days for you and, if married, for your spouse.

☐ A completed ***Self-Employment or Rental Income Worksheet/Reporting Form***.

☐ A **signed, dated letter from each adult who has not received income from any source,** stating they had no income for the past 30 days.

☐ Copies of letters or statements showing **proof of all benefits your family received.**

☐ **Current proof that you live in Washington State, showing your name and current street address (not a post office box).**

☐ Other:

*To print a *Self-Employment or Rental Income Worksheet/Reporting Form* or *Family Income Worksheet/Reporting Form*, visit **www.basichealth.hca.wa.gov/recert.shtml,** or call 1-800-842-7712 to request one.

You must read and sign the statement on the back of this page.

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I understand that:

- I must provide proof of my gross family income (before taxes and deductions) and report income changes that would change my premium or eligibility to BH within 30 days after the end of the month that the new income was received.
- My signature on this form authorizes BH and the Department of Social and Health Services (DSHS) to verify my eligibility information and family income with other state or federal income reporting agencies or other third-party sources.
- I must report address changes and changes in my family within the timeframes shown in the *Member Handbook*.

I authorize any health plan or medical provider to give medical records for me or my children to BH, for purposes of participation in the BH/Medical Assistance Administration programs.

I declare, under penalty of perjury, the information I have given on this recertification form and the documents provided are true, correct, and complete to the best of my knowledge. I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under Basic Health or additional premium amounts due, and may face other penalties, prosecution, and collection.

Must be signed by you and your spouse

X_____		X_____	
Your signature	Date	Spouse's signature	Date

Signatures of children age 18 and over who receive Basic Health coverage

X_____		X_____	
Signature	Date	Signature	Date
X_____		X_____	
Signature	Date	Signature	Date

Privacy statement: Washington State law may require disclosure of any information you submit as a public record. Basic Health is administered by the Health Care Authority (HCA); our Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.